EXAMINING THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT IN NORTH CAROLINA

CHAPTER 1: INTRODUCTION

In March 2010, Congress passed national health reform,[1] referred to throughout this report as the Affordable Care Act (ACA). The ACA was enacted to address certain fundamental problems with our current health care system, including the growing numbers of uninsured, rapidly rising health care costs, poor overall population health, and uneven quality of care. The ACA expands coverage to the uninsured, focuses on prevention to improve population health, places an increased emphasis on quality measurement and reporting, and tests new models of delivering and paying for health care to reduce unnecessary expenditures.

PROBLEMS WITH THE CURRENT HEALTH CARE SYSTEM

Growing Numbers of Uninsured

In 2010, when the legislation was passed, 18.4%[2] non-elderly Americans did not have health insurance. At the same time, 19.6% of nonelderly North Carolinians, or 1.58 million, were uninsured.[3] Not having health insurance coverage is harmful to the health and well-being of children and adults. People who lack health insurance coverage have a harder time affording necessary care. In a statewide survey of adults, nearly half of the uninsured in North Carolina reported forgoing necessary care due to cost, compared to 11% of individuals with insurance coverage.[4] More importantly, the lack of coverage adversely affects health. The uninsured are less likely to get preventive screenings and ongoing care for chronic conditions. Consequently, the uninsured have a greater likelihood than people with coverage of being diagnosed with severe health conditions (such as late stage cancer), being hospitalized for preventable health problems, or dying prematurely. [5]

The chief reason that people lack coverage is cost. Rising health care costs over the past decade have led to decreases in the number of employers offering health insurance and the number of employees who can afford the premiums when health insurance is offered.[6] In 2010 the average annual total premium cost for individual coverage through an employer in North Carolina was $4,992, with the employee picking up 22% of the cost.[7] Family coverage cost, on average, was $13,221, with the employee picking up 28% of the cost.[8] Between 2003 and 2011, average total premiums for employer-sponsored family coverage rose nationally by 62% (from $9,249 to $15,022). During that same time, the average employee premium contribution rose by 74% (from $2,283 to $3,962) and average per-person deductibles more than doubled (from $518 to $1,123).[9] Individuals who do not have access to employer-based coverage and who are not eligible for public insurance rely on the limited non-group coverage market for health insurance. The premium costs for non-group coverage can be extremely high and the individual must pay the full cost of the premium, with no contribution from their employer. Furthermore, in most states, insurers can deny coverage completely, impose limits on coverage for those with preexisting conditions, or charge higher premiums based on health status, occupation, and other personal characteristics. Uninsured North Carolinians report that the main reason they do not have health insurance is they cannot afford the premiums.[10]

Rising Health Care Costs

This rapid growth in premiums stems from an increase in underlying medical costs. High costs and utilization of medical technology and prescription drugs have fueled the increase in health expenditures. Additionally, the growing prevalence of chronic illnesses contributes to escalating premiums.[11] In addition, there is significant waste in our health care system, including fraud and abuse,[12] as well as unnecessary expenses due to poor delivery of health care services, fragmented and disjointed care, and overtreatment.[13]

Health care accounts for a remarkably large portion of the United States' economy. In 2010, the United States spent $2.6 trillion on health care, an average of more than $8,000 per person (up from $1,110 in 1980).[14] The percentage of the gross domestic product (GDP) devoted to health care increased from 7.2% in 1970 to 17.9% in 2010. During this time, health care costs per person have grown an average of 2.4 percentage points faster than the GDP.[15] As discussed, the increases in health care costs impact the ability for employers to offer insurance and for individuals to afford insurance. Rising health care costs also impact government programs such as Medicaid and Medicare, which are major parts of federal and state budgets. Rising health care costs contribute to our federal deficit and reduce our ability to spend in other areas such as education, transportation, and economic development.

Poor Overall Population Health

Americans are generally in poorer health than our counterparts in the developed world. This may be why we spend more than most other countries yet have similar—or worse—health outcomes. As population health worsens, costs to both individuals and the health care system as a whole continue to rise. National rankings show the United States ranks 30th out of 34 OECD countries in terms of premature mortality and in the bottom third for infant mortality and mortality due to heart disease. The United States has more obese adults than any other OECD country.[16] Examining 50-state data shows that North Carolina often ranks near the bottom of the states on measures of population health. In 2012, North Carolina was ranked 33rd in overall health (with 1 being the highest).[17] North Carolina ranks poorly on many health outcomes, health behaviors, access to care, and socioeconomic measures.

Poor or Uneven Quality of Care

While the United States spends significantly more than other countries on health care, our countries' performance on measures of health care quality is mixed. The United States ranks in the bottom third on measures of asthma and chronic obstructive pulmonary disease (COPD) hospitalization, obstetric trauma, and childhood vaccinations.[18] The United States ranks in the top third for five-year survival rates for patients with three types of cancer, and near the middle on measures of in-hospital, case specific mortality for three conditions.[19] These findings suggest that there is much room for improving the quality of care delivered within our health care system.

When compared to other states, North Carolina ranks 25th on potentially preventable use of hospitals and costs of care.[20] In a national comparison of health system performance, which includes 63 measures across five domains including access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives, North Carolina ranked 41st in 2009 (with 1 being the highest performing state). This low ranking was due, in large part, to significant health

disparities and poor performance on health outcome measures. While North Carolina performs better in health care performance than in health outcome measures, there is still considerable room for improvement. For example, the analysis suggests that 131,627 more adults with diabetes in North Carolina would have received recommended clinical services to prevent disease complications if North Carolina performed as well as the best state. Similarly, North Carolina would have experienced 23,384 fewer preventable Medicare hospitalizations saving close to $146 million.

The Affordable Care Act

The ACA was enacted to address these fundamental problems with our current health care system as well as to increase the supply of health professionals and strengthen the health care safety net.[21] The federal legislation also includes provisions aimed at reducing health care expenditures. While the ACA offers new opportunities to expand coverage, improve population health and quality of care, and reduce health care costs, the legislation creates new challenges for the states as well as for families, businesses, health care professionals, and organizations. In order to implement the new law, the North Carolina Department of Health and Human Services (NCDHHS) and the North Carolina Department of Insurance (NCDOI) asked the North Carolina Institute of Medicine (NCIOM) to convene workgroups to examine the new law and gather stakeholder input to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole.

NCIOM Workgroups

At the request of NCDHHS and NCDOI, the NCIOM convened stakeholders and other interested people to examine the new law and to ensure that the decisions the state makes in implementing the ACA serve the best interest of the state as a whole. The effort was led by an Overall Advisory Group, which was chaired by Lanier M. Cansler, CPA, Former Secretary, North Carolina Department of Health and Human Services,[22] Albert Delia, Acting Secretary, North Carolina Department of Health and Human Services, and G. Wayne Goodwin, JD, Commissioner, North Carolina Department of Insurance. The Overall Advisory Group included an additional 40 members, including legislators, agency officials, leaders of the state's academic health centers, and representatives of health care professional organizations, insurers, business, consumer groups, and philanthropic organizations. In addition to the Overall Advisory Group, eight other workgroups were charged with studying specific areas of the new act: Health Benefit Exchange; Medicaid; Safety Net; Health Professional Workforce; Prevention; Quality; New Models of Care; and Fraud, Abuse, and Overutilization. (See Appendix A for a complete list of all Workgroup and Steering Committee members.) Altogether, 260 people from across the state were members or steering committee members of one or more of the nine groups. In addition, the meetings were open to the public so that many others have participated in the meetings either in person or online.

Each workgroup was tasked with studying specific areas of the ACA and providing advice to the state about the best way to implement these provisions as well as examining federal funding opportunities in their area. The workgroups were guided by their co-chairs and the steering committee. The workgroups began meeting in August 2010 and met for 12-18 months. Each workgroup developed recommendations based on the information they were tasked with studying. An interim report was published in March of 2011 with the recommendations of the

workgroups at that time. (The interim report is available online at http://www.nciom.org/wp-content/uploads/2011/03/HR-Interim-Report.pdf.) The workgroups continued to meet and develop their final recommendations, which are contained in this report. The final recommendations of each workgroup were reviewed by the Overall Advisory Committee, which was charged with overseeing and coordinating the work of all the workgroups. The Overall Advisory Committee reviewed and revised the recommendations, then sent the recommendations to the NCIOM Board of Directors for review. The NCIOM Board of Directors reviewed, revised, and approved of the recommendations within this report.

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[1] The ACA is actually a combination of two separate pieces of legislation. The Patient Protection and Affordable Care Act (HR 3590) was signed into law on March 23, 2010. This law was quickly followed by the Health Care and Education Reconciliation Act (HCERA) (HR4872), which was signed into law on March 30, 2010.

[2] Assistant Secretary for Planning and Evaluation (ASPE). United States Department of Health and Human Services. ASPE Issue Brief: Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey. http://aspe.hhs.gov/health/reports/2011/cpshealthins2011/ib.shtml . Published September 2011. Accessed January 29, 2013.

[3] North Carolina Institute of Medicine. Characteristics of Uninsured North Carolinians: 2009-2010 Data Snapshot. http://www.nciom.org/wp-content/uploads/2010/08/Uninsured-Snapshot_0910.pdf . Accessed January 29, 2013.

[4] State Center for Health Statistics. Division of Public Health. North Carolina Department of Health and Human Services. 2011 Behavioral Risk Factor Surveillance System (BRFSS) Survey Results: North Carolina. Health Care Access--By Risks, Conditions, and Quality of Life Measures. http://www.schs.state.nc.us/schs/brfss/2011/nc/risk/medcost.html . Accessed January 29, 2103.

[5] Committee on Health Insurance Status and Its Consequences, Institute of Medicine of the National Academies. America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: National Academies Press; 2009.

[6] Committee on Health Insurance Status and Its Consequences, Institute of Medicine of the National Academies. America's Uninsured Crisis: Consequences for Health and Health Care. Washington, DC: National Academies Press; 2009.

[7] National Conference of State Legislatures (NCSL). Health Insurance: Premiums and Increases. http://www.ncsl.org/issues-research/health/health-insurance-premiums.aspx . Published January 2013. Accessed January 29, 2013.

[8] National Conference of State Legislatures (NCSL). Health Insurance: Premiums and Increases. http://www.ncsl.org/issues-research/health/health-insurance-premiums.aspx . Published January 2013. Accessed January 29, 2013.

[9] Schoen C, Lippa J, Collins S, and Radley D. State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action. http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Dec/State-Trends-in-Premiums-and-Deductibles.aspx . The Commonwealth Fund. Published December 12, 2012. Accessed January 29, 2013.

[10] State Center for Health Statistics. Division of Public Health. North Carolina Department of Health and Human Services. 2011 Behavioral Risk Factor Surveillance System (BRFSS) Survey Results: North Carolina. Uninsured. http://www.schs.state.nc.us/schs/brfss/2011/nc/all/noinsure.html . Accessed January 29, 2013.

[11] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[12] Goldman TR. Eliminating Fraud and Abuse. Health Affairs. Health Policy Brief. July 31, 2012. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_72.pdf. Accessed January 29, 2013.

[13] Lallemand NC. Reducing Waste in Health Care. Health Affairs. Health Policy Brief. December 13, 2012. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_82.pdf. Accessed January 29, 2013.

[14] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[15] Kaiser Family Foundation. Health Care Costs: A Primer. http://www.kff.org/insurance/upload/7670-03.pdf. Published May 2012. Accessed January 29, 2013.

[16] Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2011: OECD Indicators. http://www.oecd.org/els/healthpoliciesanddata/49105858.pdf . Published 2011. Accessed January 29, 2013.

[17] United Health Foundation. America's Health Rankings: North Carolina 2012. http://www.americashealthrankings.org/NC/2012 . Accessed January 29, 2013.

[18] Organisation for Economic Co-operation and Development (OECD). Health at a Glance 2011: OECD Indicators. http://www.oecd.org/els/healthpoliciesanddata/49105858.pdf . Published 2011. Accessed January 29, 2013.

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[21] A more complete description of the ACA is available in the May/June 2010 issue of the NCMJ. Silberman P, Liao C, Ricketts TC. Understanding health reform: a work in progress. *NC Med J*. 2010;71(3):215-231. http://www.ncmedicaljournal.com/archives/?issue-brief-understanding-health-reform-a-work-in-progress-3733. Accessed January 18, 2011. A review of the steps the state has taken to implement the ACA is available in the March/April 2011 issue of the NCMJ. Silberman P, Cansler LM, Goodwin W, Yorkery B, Alexander-Bratcher K, Schiro S. Implementation of the Affordable Care Act in North Carolina. *NC Med J*. 2011;72(2):156-160. http:// http://www.ncmedicaljournal.com/wp-content/uploads/2011/03/72218-web.pdf. Accessed February 14, 2012.

[22] Secretary Cansler served as co-chair during his tenure as Secretary of the North Carolina Department of Health and Human Services. Secretary Delia became co-chair when he was appointed as Acting Secretary.